

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 M I P A I L 2 0 0 - 0 0 0 0 0 0 - 0 0 0 3 4 1 1 1 1 4 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58

CON'T
01 REPORT SOURCE L 6 0 5 1 0 0 0 2 5 5 7 0 1 0 2 7 9 8 0 2 0 1 7 9 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
02 During testing of RPS power range channels NIO5, 06 and 07, these channels
03 were bypassed w/o first tripping NIO8 (which was considered at that time
04 to be inoperable). Although it was later determined that NIO8 was
05 operable at the time of the testing, the inadequacies in the administra-
06 tive controls are reportable per T.S. 6.9.2.b.3. Upon discovery, firmer
07 controls (caution tags) were used to control the use of the RPS bypass
08 keys. No hazard to public health or safety existed.
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SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE
11 12 13 14 15 16
A A X I N S T R U X 4

EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
7 0 0 0 1 0 3 L 0

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRC-4 FORM SUB PRIME COMP SUPPLIER COMPONENT MANUFACTURER
13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100
X H Z 0 0 0 0 Y N N C 4 9 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
10 This occurrence resulted from the failure to use administrative controls
11 which would provide a lasting reminder regarding the status of and
12 special requirements related to testing the RPS power range channels.
13 This occurrence will be reviewed with applicable personnel.
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FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION
15 E 10 C N/A A Review
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE
16 Z Z N/A N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION
17 0 0 0 2 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PERSONNEL INJURIES NUMBER DESCRIPTION
18 0 0 0 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION
19 7 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

PUBLICITY ISSUED DESCRIPTION
20 1 N/A
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

NRC USE ONLY
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Discussion/Description of Occurrence

During October 1978, reactor power range NI-08 failed. Investigation revealed a faulty electrical connector at the containment building electrical penetration. The connector was replaced, but because the replacement connector could not be certified to meet post-accident conditions, the channel was not declared operable. However, because the channel was operating satisfactorily and was capable of providing a trip signal to the Reactor Protection System (RPS) trip logic, it was placed in service. On January 2, 1979, during monthly testing of the RPS, the power range channels were bypassed one at a time in accordance with the test procedure. Because power range NI-08 had not yet been declared operable, the bypass of any of the other channels without first placing NI-08 in a tripped condition represented a condition which appeared to be less conservative than that permitted by the limiting condition for operation of Technical Specification 3.17. Prompt notification per the requirements of Technical Specification 6.9.2.a was made. Subsequent to this occurrence, it was determined that the containment penetration electrical connector for NI-08 was qualified for accident conditions, and that NI-08 has been capable of performing its intended safety function during both normal and accident conditions. As a result, during the testing on January 2, RPS operability requirements were met. However, there were inadequacies in the implementation of administrative controls which threatened to reduce the degree of redundancy within the RPS, and this condition is reportable per Technical Specification 6.9.2.b.3.

Cause Description

On November 1, 1978, instructions were placed in the Daily Orders Book to control use of the RPS bypass keys in a manner such that an RPS power range channel would not be bypassed unless NI-08 was first placed in a tripped condition. Because of the lengthy time span between the Daily Orders Book entry and the January 2 testing, supervisory personnel and personnel conducting the testing were no longer aware of Daily Orders Book requirements. Because NI-08 was in service and operating normally, testing personnel presumed it was operable. Better administrative controls in the form of caution tags on either the RPS bypass key or on the NI-08 drawer would have provided a lasting reminder of the NI-08 status, and would have prevented this occurrence.

Corrective Action

Upon discovery, the bypass keys were caution-tagged. This occurrence has been reviewed with technicians and will be reviewed with applicable operating personnel.